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THE EMPLOYMENT EXAMINATION FOR PSYCHIATRIC CASUALTIES

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The armed forces have been releasing psychiatric casualties at the rate of 30,000 per month. The total at the end of the war will exceed a million.

Soldiers who have suffered physical wounds, particularly those who have been maimed, disfigured, or lost sight or hearing, may need help in readjusting emotionally to civilian life and employment.

History shows that a considerable percentage of healthy ex-soldiers have always had difficulty in settling down. We may anticipate a similar temporary restlessness in many veterans of this war.

Publicity, aimed at preparing us to support and aid the rehabilitation of these veterans, has created something akin to panic in the minds of many by giving the impression that a horde of what the newspapers call "raving maniacs" were being turned loose in increasing numbers and that employers were expected to provide work for them. This is not true.

Psychotics (the insane) constitute only a very small percentage of the total psychiatric casualties. They will be hospitalized until improved or cured. They hardly enter the industrial problem.

The vast majority of the psychiatric casualties from this war are psychoneurotics. (What these are will be explained later). With these, industrialists are familiar because they have always had many psychoneurotic employees.

Certain psychoneurotic traits are responsible for most personnel problems. Among these have been discontent leading to labor troubles, accident-prone employees, poor workmanship, inability to assume responsibility, erratic behavior, inability to get along well with others, and much absenteeism.

Psychoneurotic fears and feelings of inferiority, often expressed in belligerency, touchiness, inability to accept criticism, outward superiority and other evidences of overcompensation, are almost invariably the great factors in preventing intelligent men from learning how to handle others well. They, far more than anything else, prevent the development of good supervisors and executives.

It is common knowledge that organizations reflect the personalities of those who head them—for good or evil; that men work their heads off—and enjoy doing it—for certain leaders but not for others. It has not been so clearly recognized that the difference depends almost entirely upon the presence or absence of certain psychoneurotic traits in the leaders.

Lest this be misunderstood and all psychoneurotics condemned out of hand, it must also be known that other psychoneurotic traits may drive men to work harder and be more conscientious than the average man and thus make them very desirable employees. Some of our greatest men, Abraham Lincoln for example, were psychoneurotics but their psychoneurotic traits were not the kind that disturb others.

The near-panic which is developing has no actual basis. It is a fear of strange-sounding names—the psychiatric diagnoses applied to the psychiatric casualties. These, in reality, are no more dangerous than was Orson Welles' broadcasted "Invasion From Mars" which created such a panic a few years ago. Both arouse the same kind of fear—the ghostly fear of the unknown.

But no one ever became frightened of a ghost in broad daylight and the recognition and diagnosis of psychoneuroses is a first necessary step in bringing the great problem of the emotional disturbances of normal civil-

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ized man into the open where the light of reason can be applied to its solution.

It has been pleasant to discover that an increasing number of executives and other leaders have now recovered from the ancient ghostly fear of mental disturbances to the point of accepting their existance—even in themselves. They commonly exhibit such acceptance by their readiness to bring up in open meeting the question: "Aren't we all a little nutty?"

DEFINITION OF THE PROBLEM

The re-employment of veterans, whether disabled or not, will present problems to industry. They will be new problems only in the sense that they will be greater in volume. Some of them will pertain to employees other than veterans.

Among the latter will be the emotional disturbances engendered in civilians by changes in their way of life made necessary by the war; discontent resulting from the displacement of employees who have worked faithfully throughout the war but who will be bumped into poorer jobs by veterans with greater seniority; and men who have been assigned to government plants in better paying positions than those to which they will return.

Men who left minor positions to enter the armed forces and who have become officers will hardly be content to return to the jobs they left. One company now wonders what they will do with the former office boy who has become a Lieutenant Colonel in the Air Corps.

There will be engineering as well as emotional and other personnel problems to be solved in connection with the re-employment of the blind, the deaf, the crippled and those who have lost limbs.

A man with one arm amputated at the shoulder reported by Drs. Whitney and Brody of the Sperry Gyroscope Company, required psychiatric treatment before he would attempt training, then training as a machine tool operator and finally a special control lever for his machine tool which he could operate with his shoulder was devised by the engineering department. He then became over-confident and insisted on a job he was physically unable to handle. The trial convinced him and, with a little further aid from the psychiatrist, he settled down into a productive employee.

The industrial and safety engineer will have to help solve similar problems presented by the blind, deaf and maimed.

Management, personnel, and supervision will likewise find their loads increased by having a greater number of unstable individuals in the plant. They will find it helpful to learn all they can about such people in order to be able to handle them better.

Education of the workmen themselves, and particularly of their union officers, will be essential. One veteran reacted to sudden loud noises as if they were exploding shells. Workmen who thought this was funny started to throw pop bottles to break near him.

Such practices can be stopped when workmen are taught to understand that, even though such men act "tough," it makes them feel very badly. They need to realize, too, their indebtedness to such veterans and that they, if they had undergone similar terrible experiences, would probably be as bad or worse.

Training in new jobs will be necessary in some cases. Likewise retraining for the same job previously held. But, in my opinion, it is unwise to assume, as some executives have, that all veterans will require training or that all will require the same amount. Equally dangerous is the assumption that all veterans will require special supervision for a fixed period of time.

Some executives have assumed that sinecures should be provided for disabled men. This would create discontent in others and harm the veterans.

One of the outstanding basic symptoms of the veterans I have examined has become a feeling that, as a result of their war experience, they have become a different kind of man from civilians. Providing them with sinecures or treating them differently from other employees in any other way that suggests coddling will accentuate this feeling and make them worse rather than better.

If they are to be honored for their service to the country, as they well deserve to be, such honor should be expressed in ways other than

those which imply special privilege or special attention longer than necessary to get them back to work again. Nor should they be treated better, when they first return, than they will be treated later.

The satisfactory solution of all these problems will require close cooperation and liaison between management, personnel departments, supervision, workmen and their unions and the medical department. When this is developed much can be learned which will be forever useful in handling the psychoneurotic kinks and quirks which always have created problems in industry.

PSYCHONEUROTICS

The remainder of this paper will be devoted to the specific problems involved in the examination and placement of psychiatric casualties. These are, primarily, medical problems. The plant physician must, therefore, be prepared to examine, evaluate, and advise as to placement. He must also be prepared to advise and assist in the education of everyone else in the plant about them and their management.

Because this is true, this paper is directed primarily to industrial physicians. Psychiatric jargon without definitions will, however, be avoided and the paper may prove interesting to management and personnel.

KIND OF PSYCHIATRIC CASES

The vast majority of the psychiatric casualties from this war are psychoneurotics and most of these are anxiety cases. The latter are usually serious, conscientious, tense, hard-working individuals of whom we have always had many in industry. They may suffer from attacks of shakiness, fears without real cause, such as of heart failure, and some of them have specific phobias such as claustrophobia, a fear of heights, etc. Irritability is usual but often well hidden. Greater anxiety than their situation justifies is invariably found. They often complain of insomnia and disturbing fearful dreams or nightmares.

On physical examination they are found to have unstable pulse and systolic blood pressure and a tendency to perspire when it is not hot. They may have tremors and otherwise act "nervous."

The other types of psychoneurotics who are being discharged from the armed forces are also familiar to us. Hysteria, exemplified by the man with a nervous stomach, is common. Likewise, the "nervous" heart. Most of us know some of them in high places.

Such symptoms do not preclude working, provided they are not too severe. Simply making a diagnosis of the psychoneurosis is of no importance in connection with re-employment. The important question with most of them is not whether they can work but that of placement in suitable jobs.

The armed forces are making a special effort to eliminate homosexuals. These men constitute no problem in civilian employment so long as they act normally while at work, which most of them have sense enough to do. Some of them are brilliant, useful, employees and, without a psychiatric examination, their condition would never be suspected. Why hunt trouble?

Another psychiatric group—the psychopaths—are nothing more or less than those who resent and fight authority. They are non-conformists. Most of us exhibit the same traits at times. Whether they can work depends entirely on how they exhibit their non-conformity or how much trouble they stir up.

Over 600,000 mental defectives were rejected and others are being discharged. Of these, the idiots and imbeciles almost never apply for jobs. The morons not only apply but, placed in appropriate jobs, make steadier and better employees than those of higher intelligence who more readily become bored in monotonous tasks.

The temporary restlessness of the discharged soldier should be remembered in connection with placement. A restless individual who will not fit well in a job where he has little activity. The mistake should not be made, for example, of placing a restless soldier as a guard merely because he knows how to handle a gun. He would probably fret himself into an illness or quit.

PURPOSE OF EXAMINATION

The primary purpose of the examination will be that of proper placement.

True, the examiner should first determine whether the veteran is employable. But most

of those who apply will be employable and this determination is of secondary importance in most cases.

In some cases no single examination will determine either of these points. As shown by the vast experience of the armed forces, even after repeated examinations by the best of psychiatrists, only a trial, sometimes in various placements, will disclose what they can do.

This does not excuse an examiner from making every effort to determine and recommend the best placement for each applicant. In order to do this he needs to know all he can about the applicant. He must also have a clear picture of all jobs available in his plant; of the working conditions in detail; of the personalities of the individual supervisors; and, if possible, of the workmen. He must, in other words, know all the characteristics of both pegs and holes to achieve good fits.

Another purpose of the examination is the opportunity it provides for beginning the reorientation of the veteran to civilian life and employment. The more "gripes" he gets off his chest about his experiences in the armed forces, and about attitudes of civilians of which he disapproves, the more ready he will be to settle down to his job. The expression of such gripes provides the examiner an opportunity for explaining to the veteran why, in a hastily raised army, such things are inevitable, and that civilians are incapable of appreciating what the veteran has experienced during his service.

MEDICAL EXAMINATION ESSENTIAL

Examinations to serve these purposes are a function of the industrial physician. Even though he may not be qualified in psychiatry and even though the best of psychiatrists are far from being infallible, the industrial physician, with or without psychiatric training, has far more of the essential qualifications than any other group of people.

This does *not* mean that the industrial physician is alone responsible for obtaining histories of the applicant, for observing him and for planning how to place him back to work. Neither does it mean that he cannot and should not get invaluable assistance from management, personnel, supervision and workmen. The unions have definite responsibilities. The industrial physician cannot possibly do it alone.

It does mean that the industrial physician is responsible for obtaining the best possible histories of the case; making the best possible examination of the individual; and recommending to management, personnel and labor the best treatment available.

He may need various tools to accomplish this. He may find technical aids invaluable, just as he does in physical examinations when he calls upon x-ray and other laboratory technicians for help. But such aids should, if he is to be held responsible for the results, be under his control.

PSYCHOLOGICAL TESTS

It seems necessary to make such statements because, in the field of mental disturbances, there are others who believe themselves qualified to assume such responsibilities. Various psychologists, for example, have invented aptitude and personality tests which, they claim, may be administered by themselves or by untrained or slightly trained laymen or by applicants themselves to determine what a man can do and whether he will exhibit psychoneurotic traits which will in the future interfere with his ability to work.

Some of our best psychologists readily admit that the value of such tests is unproved. They admit this of tests which they themselves have developed.

With one exception, so far as we have been able to learn, no effort has been made to evaluate any of these tests by following tested individuals over a period of subsequent years to check their actual performances against prophecies based on the tests.

In the exception noted, a whole battery of psychological and other tests were administered to a large group of prospective air pilots, the results scored and filed, the applicants hired and put into training as commercial airplane pilots. When the training was completed, it was found that *none* of the tests had *any* value in determining which applicants would succeed. Those who actually made good included many who had received low and very low ratings on all the tests. The

failures included some who made high scores on the tests.

Nothing stated above should be taken to mean that we are opposed to such tests when their value has been proved. We intend, in fact, to attempt an evaluation of some of them ourselves. But, to date, their value is unproven and their indiscriminate use by untrained people can be as dangerous as a similar use of surgical instruments or an x-ray machine.

History

What is known to social workers as a social history and to psychiatrists as a psychiatric history is of greater value in the psychiatric examination than is a medical history in a medical.

If we could obtain the perfect, complete, psychiatric history and thus learn not only how the individual reacted to the events in it, but why, we could come close to prophesying how he would react to similar situations and events in the future. Individual cases would fool us just as they do in physical medicine. But on the average our prognoses on future behavior would be fairly accurate.

The aim of the psychiatric history is to obtain such a picture.

Outlines for such histories can be obtained from textbooks on psychiatry or social work. The manual of the New York State Mental Hospital Service, obtainable from the Commissioner of Mental Hygiene at Albany, New York, includes a concise outline together with brief useful explanatory notes.

Such a history is, however, nothing more than a complete medical history plus a story of the patient's emotional history so far as this can be obtained. It attempts to picture the emotional environment in which the individual grew and lived, together with all possible indications as to how he reacted to these.

Every experienced physician has observed children being spoiled at home during a chronic illness. He has seen others with equally severe and prolonged illnesses who were not spoiled. Such illnesses, in the history of an individual, may therefore have important effects on his subsequent life.

But these effects will depend upon how he was treated during and after them. His treatment, in turn, will depend upon the personality of his parents and their reactions to the illness. The worrisome mother will spoil him. She will also transmit to him her fears which are just as contagious as measles. Having caught them, he may react by becoming an equally worrisome individual—a hypochondriac. But he may also react in the opposite direction, attempt to defy the fears, overcompensate in this direction and become the kind of individual who denies any need for taking care of his health and who has no use for doctors.

The possible events which may become important in the life of a given individual are endless. So are the possible reactions of the individual to them. The same events, in different cases, may be of crucial importance or none, depending upon the emotional attitudes and reactions exhibited by parents and other adults. Of the two, events or emotional reactions of parents, the latter is by far the more important. Indeed, even without special events to point it up, the emotional atmosphere created by the parents will have profound effects upon the child.

No one knows this better than the physician. He has learned that even the apparently very fearful child, removed from the fearful mother, often discloses great calm in the presence of painful emergencies.

Physicians also know, if they recall it, that the same mother focuses different emotional attitudes on her individual children, depending on her own beliefs (often false) about them. Once she concludes a child is delicate, for example, she will, under the influence of her resultant fears, do everything possible to frighten him into invalidism.

Doctors sometimes do the same thing, unnecessarily and unintentionally, as a result of their failure to correctly evaluate the emotional make-up of their patients. Learning to do the last is, therefore, important to them in their practice of physical medicine as well as with psychiatric cases. Learning how to secure a social history is a first step in achieving this ability.

Once they realize that this is no esoteric procedure, however, they will discover that they need do little more than systematize

knowledge they already possess. Every physician probably knows the subjects to which Americans generally are apt to react strongly; the life situations which most often make the strongest impressions. These, brought together, constitute the outline for a psychiatric history.

Such an outline should bring out what his parents or other adults who had charge of him during the impressional years of childhood were like and how he reacted to them; the same sort of information about his friends, sweethearts and wife (if married); his children (if any) and about outside authorities beginning with school teachers through bosses and, in the case of the veteran, his officers.

We need to learn also how he reacted to illness, success and failure. Likewise to certain subjects, commonly charged with considerable emotion, such as health and disease, work, sex, religion, politics, etc. His ideals and ambitions often aid in evaluating his acceptance of reality. The moron whose mind is set on becoming a physician is doomed to disappointment.

What can we expect to obtain by delving into such attitudes and reactions? Simply a picture of the general pattern of the patient's attitudes and behavior in the past from which we may anticipate how he will react in the future.

Not that definite prophecies are possible and infallible. Circumstances change and, in varying degrees, people change in reaction to them. Usually, however, the individual who could not get along with his first authorities, his parents, nor with teachers and later with his superiors at work, will continue to rebel against authority. If he had trouble with the police for lawbreaking, the outlook is worse.

Likewise the person who was always too submissive, who never displayed initiative, who is still tied to his mother's apron strings, will be apt to exhibit similar attitudes and behavior toward his superiors at work if employed. But he will also be apt to demand similar submissiveness from subordinates, if he achieves authority, and even to bully them into it. Such men may be very good workmen but very poor supervisors.

The variations in such patterns are infinite in variety, often confusing and apparently contradictory on the surface. The previously rebellious, unreliable individual sometimes finds the right kind of teacher, boss, friend, sweetheart or wife and shows a marked change for the better which may or may not be lasting. Likewise, men change for better or worse after other great emotional experiences, such as religious conversion, a complete change in environment such as occurs when a man enters the army or when anyone attains success and fame in business or profession. In another category come the reverses in life—loss of loved ones, of money, reputation, etc.

How to Obtain A Psychiatric History

What has been stated above may give the impression that obtaining a psychiatric history is a formidable task. It is, at first. But this was true of medical histories when, as a medical student, the physician was first introduced to them. In time, as his knowledge, increased, it became easier. Eventually it became second nature. The same thing occurs with regard to psychiatric histories for those who make the effort to learn how.

Any well-organized industry, in fact, has already obtained part of such a history before the industrial physician sees the applicant. The questionnaires, filled out in connection with the employment interview, together with the observations and opinions of the employment interviewer, reports from references and from investigators, constitute the nucleus of a psychiatric history. The industrial physician should have such records in connection with examinations. With former employees there will be, in addition, a record of past performance and evaluations of his work.

Scrutiny of such records will suggest the need for further questioning. Failures in school, as the physician knows, may be due to mental deficiency, to lack of interest, or to trouble with teachers resulting in unfair grading. Questioning will usually indicate the why in the individual case. It may also disclose the applicant's attitude toward authority.

A work record showing many changes of employment likewise brings up the question

of why. Discharge from the armed forces, before the war is over, likewise. Failure to win any promotion during a long term of service also suggests possibilities for investigation.

The History of Present Illness

Under present laws and rulings Army medical officers are not permitted, in psychiatric cases, to report their findings to outside physicians, even when requested by the man himself, nor to inform the man what diagnosis they have made. Presumably the same rulings apply in the Navy.

Officers of the Veterans' Administration are permitted to offer some information and advice in connection with patients who have been transferred to them, provided this is requested by the patient.

U. S. Employment Service officials likewise have medical information about applicants discharged from the armed forces. Their opinions as to the employability of individuals are based, in part, on such knowledge. Thus, even if they are not permitted to convey facts about the applicant's present illness, their opinions may supply valuable indications regarding the symptomatology from which the applicant suffers.

Both organizations have something to offer and the development of good liaison between them and the plant physician will increase the help they can give, not alone in the employment of handicapped veterans but also in securing treatment and special training for those who may prove to need it.

In a large percentage of cases it is possible for the plant physician to obtain all the history of the present illness he will need from the veteran himself if the art of accomplishing this is developed. The best time, in my experience, is after the physical examination has been completed. The examination tends to establish in the patient's mind the same feeling he has had with his own doctors and by the time it is completed he has largely recovered from his nervousness about being examined for a job. The good relationship is enhanced if the results of the physical examination are first discussed with him.

It will be found that some applicants for both employment and re-employment, whether veterans or not, will talk more readily to one individual than to another. In one case, therefore, the personnel men can obtain more useful information than the doctor and vice versa. Or it may be the supervisor, the office receptionist, or the nurse. Recognition of this leads to utilization and suggests the need for the education of all of these in history taking and recording. In some cases a nurse or employment interviewer with a flair for history taking might be taught to take over the task.

The manner of approach is important in obtaining a history, regardless of who secures it. An attitude of respect for the applicant and his story is a first essential. He will usually be glad to talk and find relief in doing so if we avoid certain common pitfalls.

The examiner must realize, as a pre-requisite, that he is utterly dependent on the man for information necessary in making a good placement. He will get nowhere if he has the attitude that psychiatric complaints are purely imaginary, no matter how hard he tries to conceal such an attitude.

The psychiatric patient has met this attitude all too often among laymen who expressed it by telling him to snap out of it. He is, as a result, highly sensitized to it. He fears the doctor will exhibit it and comes in suspicious and watchful for it, ready to resent it and shut up if he finds it.

His attitude is fully justified. The physician who descends to this smug level is overcompensating for his own ghostly fear of finding psychoneurotic reactions in himself. His assumption of this attitude discloses the existence of that which he attempts to hide.

The patient does not think of the last. But he does sense some sort of deceit. He is, however, desperately looking for someone who will understand that his condition is real and psychically painful and to such a person, once found, he will be more than willing to unburden himself.

In doing so he will disclose both the kind and severity of his symptoms and thus supply the examiner with the facts he needs to determine whether the man can work and where to place him.

When this occurs, the applicant also finds, in most cases, some relief from his symptoms.

Even if this be but temporary he is apt to return to the same physician for further help if he needs it.

This relationship will, however, be spoiled if the physician makes the error of advising the applicant, after hearing the story, not to worry, to snap out of it, or any other of the too common shibboleths. Saying the condition is nothing but nervousness in a contemptuous manner has a similar effect.

It is far better to admit that under similar circumstances we might very easily have developed worse symptoms, for this is the truth. *Such an admission helps to break down one of the basic psychopathological reactions of all psychoneurotics—that they are different from other people.*

MENTAL EXAMINATION

It must be apparent that the mental examination will have begun from the first moment the patient appeared. His reactions during the history taking are, as stated above, more important than his actual answers. They should, therefore, be noted in passing and explored, either then or later, when they appear to be inappropriate to the subject under discussion or more powerful than usual.

The mental examination continues during the physical examination. Observations of the patient's reactions to the examination and to nudity are often informative. A coy attitude in the presence of a doctor of the same sex suggests homosexuality. Resentfulness may be evidence of a trend against doctors, often a result of the kind of treatment he has had from previous doctors.

Anxiety commonly results in tremors, sweating, and rises in pulse rate and systolic blood pressure. It frequently causes spasticity of the colon.

Questions about the organs being examined naturally brings out complaints referrable to them which may be either physical or emotional in etiology—or a combination of the two. Evidence of tenderness over organs indicates such questions.

When evidence suggesting any emotional disturbances is found, further questioning will be needed to establish their existence. There is no excuse for jumping to conclusions. Thorough physical examination, with necessary laboratory tests, including x-rays when indicated, must not be neglected.

If no physical pathology is discovered, or *if it is insufficient to cause the symptoms,* an emotional etiology is strongly suggested. If, in addition, we learn that the applicant suffers from indigestion or other somatic symptom only after he has become emotionally disturbed, such symptom is caused, at least in part, by pathological emotions.

A good opening for questioning about the applicant's emotional life can be set up during the physical examination if, when the examiner notes evidence of nervousness, he makes comments such as "You seem to be a little nervous" or if he asks whether the applicant is always nervous about examinations. Whatever the reply, the examiner can indicate by what he then says that he will return to the subject later.

He has another opportunity to break down the psychoneurotic's feeling of being a different kind of person by telling those who admit that they are nervous during examinations that most people are.

These definite suggestions are included here merely to indicate the kind of conversation that has proved useful in helping the applicant to become comfortable so he can talk freely about his symptoms and their emotional background. An informal atmosphere and an attitude on the part of the examiner of a genuine interest is the important thing. Each examiner will do best with his own characteristic wording.

EVALUATION OF FINDINGS

Under the Selective Service Act the employer is required to provide jobs for former employees who apply for same within 90 days after discharge from the armed forces.

In all cases where the veteran is rejected, the burden of proof will be on the employer. If rejection has been on medical grounds, the examining physician will bear the brunt of providing such proof.

It is essential that no man be rejected by the examiner if he can possibly work. It is equally essential that complete records of examinations be kept in case it becomes necessary to testify in court.

The findings should be evaluated, not to

make a psychiatric diagnosis, but to reach the important decision as to whether the veteran will be able to work, and at what.

This decision cannot be made without full knowledge of both the job to be assigned and working conditions in general. This should include clear-cut concepts of all the jobs in the plant. Preferably, these will be obtained through continued personal observation. In addition, job descriptions such as are prepared by the industrial engineers in many plants will have value. With psychiatric casualties, a first-hand knowledge of the personalities of the supervisors will be equally essential. The irritable, anxious veteran will not do well with an equally irritable, nervous boss. He may do well with a calm, understanding, self-confident one.

The examiner must use his best judgment of both individual supervisors and applicants in recommending placements. Likewise, when experience shows that an error has been made—that a man and his supervisor do not mesh well—he should not hesitate to recommend a transfer.

Some executives, as mentioned above, have expressed a willingness to provide sinecures for disabled former employees. This is commendable, but not desirable. Any man, worthy of his salt, must feel that he is earning his wages in order to maintain his self-respect. Loss of self-respect is often an important factor in the causation of psychiatric casualties. Sinecures would make many of them worse and breed discontent in the individual and in his fellow-workmen. It would add to their feeling that they are different.

Where it is possible, however, to engineer jobs so that blind, crippled or otherwise handicapped individuals can turn out a full day's work, the mental health of the individuals involved is tremendously improved. The loyalty of such employees resulting in decreased labor turn-over and absenteeism and steady productivity appears to pay dividends on the extra efforts required.

With a clear picture of the plant and its supervisors in mind, and an equally clear picture of the applicant's symptomatology, the examiner will have to use his own best judgment in determining whether the man is able to work, what kind of work he can do, and under what supervision. There is no set of rules which will take the place of such judgment.

But this is no new situation for the trained industrial physician. At most it is an extension of his field of activities. He always has had to use judgment in determining whether an applicant is physically able to work at specific jobs. With a host of physical conditions, it is not a question of the presence or absence of disabilities at all, but of their severity, and then of weighing this against the requirements of various kinds of work.

The same viewpoint applies with mental casualties. In most plants of any size a trained psychiatrist could find men who are psychotic (insane). Yet some of these do their work faithfully for many years without disturbing anyone else. Under such circumstances, so long as they continue, the psychiatric condition is of no importance to the employer nor to his examining physician.

Likewise, a victim of claustrophobia can work if placed in a job which does not require that he stay in small closed spaces; the man with a fear of high places would fail as a craneman but succeed if left on the floor; the man whose stomach reacts to emotional tension may have little or no trouble if placed in a job which is largely routine under a calm supervisor.

The safety of the applicant and other workmen must be considered. A man who suffers periods of abnormal pre-occupation should never work with dangerous machines.

In doubtful cases, the applicant should be given an actual trial on the job. Some plants already have training programs or plan retraining for disabled veterans. These offer an excellent opportunity for trial and retrial to determine the final optimum placement.

Education of Others

The work of the industrial physician, in connection with the employment of psychoneuroties and others who present emotional problems to industry, is by no means complete when he has made an examination and recommendations regarding placement. He needs to be qualified to advise and educate

management, supervision and workmen how to treat them.

The educational methods to be used will vary in different plants depending upon size, facilities and other factors. But our methods do not come first. The physician cannot educate others to treat people properly until he has learned how the latter feel. And the only source of information on the last is the individual himself. The only way to get it is by direct questioning and observation of the individuals concerned. Assumptions on this subject are highly dangerous and misleading.

That this is true was taught me most forcibly by an insane patient. His family had worried for years about how to get him hospitalized. When I saw him he asked, during a pause in the examination, what was wrong with him and what he should do. When frankly informed and advised to enter a hospital, he accepted the advice without question and voluntarily entered a mental hospital. Up until then I should certainly have assumed that the viewpoint of an insane person was vastly different than this. He taught me to ask the only person who knows—the patient himself.

The industrial physician who has not learned this needs to do so. No one but a blind person can inform us about the feelings of the blind and how they like to be treated. Likewise the maimed, disfigured and deaf, the psychoneurotic and psychotic.

This does not mean that details of any applicant's history or facts elicited about his illness during examination need be divulged in connection with him. The confidential relationship must be guarded more carefully in mental cases than physical—if there is any difference.

The incompleteness of this section on education is obvious. It will emphasize the need.

SUMMARY AND CONCLUSIONS

1. The chief purpose in writing this paper has been to emphasize the fact that the reemployment of psychoneurotic veterans will thrust no new problems on industry because psychoneurotics have been successfully employed for years.

2. Psychiatric diagnosis and classification is a necessary first step toward making a realistic attitude about emotional disturbances which have, for years, presented serious problems to industry and medicine. Once recognized and accepted as such, we can begin to learn how to handle them more intelligently.

CAUDAL ANALGESIA IN OBSTETRICS*

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Continuous caudal analgesia in obstetrics must be approached with a thorough knowledge of the contra-indications to its use. These are most important. In addition to the specific contra-indications which have been set forth in previous articles on this subject, the following points should be remembered:

The technic of continuous caudal analgesia is not applicable for every woman in labor. It should never be promised to a patient, and should never be given when there is any question about her mental or physical makeup. Approximately one in every five women have some abnormality which prohibits its use.

The procedure should never be attempted by one who is not thoroughly familiar with the anatomy, physiology, and pharmacology of the subject and well trained by competent and expert instructors.

It is very important to have the patient surrounded by all of the essentials necessary to meet any emergency in case the dura is entered or a blood vessel is penetrated. This technic, therefore, should be carried out in a well equipped institution with a properly trained staff in attendance, and should never be attempted in the home or in a poorly equipped maternity department. The attending physician should, if possible, remain with his patient throughout the period of analgesia. If this is not possible, the patient should be supervised by a competently trained assistant.

Continuous caudal analgesia should never be started until the patient is in active labor

* Read before the Medical Society of Delaware, Lewes, September 12, 1944.
** Professor of Medicine, Jefferson Medical College.

and the technic should never be attempted in the presence of gluteal fold rash or pilonidal cyst.

The position and station of the presenting part, the amount of cervical dilatation, pulse, blood pressure, and fetal heart tone should be carefully checked before caudal analgesia is given. The fetal heart sounds and blood pressure should be checked at frequent intervals during the entire procedure.

Never persist in forcing the needle unless you are absolutely certain about the anatomic landmarks. If spinal fluid is aspirated, never insert the needle a second time. The full injection should not be given until ten minutes has elapsed following the initial dose of 8 c.c. making sure the patient moves her feet satisfactorily.

As these patients are in possession of their mental faculties throughout the labor and delivery, those in attendance should guard their conversation especially with regard to the condition of other patients.

One must not lose sight of the fact that infection may occur if the technic is not carried out in the proper manner. It should never be attempted if there is a proven or even questionable placenta previa.

You should not be alarmed at the drop in blood pressure, as it is quite natural, under caudal analgesia, for the blood pressure to drop 20 to 30 millimeters.

In our experience we have found that caudal analgesia shortens the first stage of labor and lessens the blood loss in the third stage.

The presenting part should not be allowed to remain too long on the perineum. Allowing for the presence of relaxation of the perineum caused by the analgesia the episiotomy should not be sutured too tightly.

Caudal analgesia has gained a permanent place in the practice of obstetrics. However, there is still a lot to learn about it and it must be used judiciously if it is to be used successfully.

807 Spruce Street

Discussion

Dr. H. vP. Wilson (Dover): One question. This subject is entirely out of my line, but is the injection continuous or intermittent?

Dr. Vaux: We give it every hour or forty minutes, repeated whenever necessary. The amount is 15 or 20 cc.

Question: Would you mind answering some of the objections that have come up in reference to caudal analgesia in obstetrics? Due to decrease in blood pressure is there interference with fetal circulation? Must high forceps be used in many cases? What is the incidence of lacerations?

Dr. E. L. Stambaugh (Lewes): I have had some experience with caudal analgesia in urology. What are your reactions to its use in this connection?

Dr. Vaux: Relative to the question of a drop in blood pressure. We must consistently watch it every 15 minutes after injection is given. If the blood pressure drops too much we give ephedrin hydrochloride immediately intravenously, which brings it back quite promptly. There is no trouble with the fetal heart sounds. And we do not use high forceps in our clinic. All are delivered by forceps but not until the head arrives at the pelvic floor. Forceps are not used when head is above the spines. A multipara can be delivered without episiotomy and we do not have many extensions of the episiotomy in the primapara. There is good relaxation and most patients can be delivered without episiotomy or other lacerations. I am unable to tell you about the urological use of caudal analgesia.

Swiss physicians report that diet deficiencies in France in calories, protein, minerals and vitamins are producing deficiency diseases, delaying growth and greatly lowering resistance to acute and chronic infections in French children. Tuberculosis, rickets, scurvy and dermatitis are rapidly increasing and living conditions as well as hunger are having a serious effect on delinquency and on the mental and social attitudes of children. In some countries there are reports of alarming increases in vision and hearing defects. In all these countries hunger is combined with suffering from cold, due to lack of fuel for homes and to lack of clothing and shoes.—Martha Koehen, Ph. D., *Ohio State Med. Jour.*, Sept., 1944.

CLINICAL CASES FROM THE HOSPITALS

CARCINOMA OF BARTHOLIN'S GLAND*

JOHN F. HYNES, M. D.,
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Adenocarcinoma arising from Bartholin's gland or duct is a relatively rare form of cancer. Ewing[1] barely mentions it, without description, in his textbook, as a source of adenocarcinomas of the vulva. Taussig[2] found nine cases in his series of 155 vulvar cancers. Novak[3] refers very briefly to cancer of Bartholin's gland, again without detailed discussion. According to a recent report by Boughton[4] about seventy-five cases are reported in the literature. Boughton's article contains an excellent bibliography.

Most vulvar cancers are epidermoid carcinomas arising from the squamous epithelium of the labia minora, labia majora, prepuce of the clitoris, perineum, urethral meatus (transitional epithelium), glans clitoridis, or fourchette. The majority of patients with such cancers also show varying degrees of leukoplakia, senile vulvitis or kraurosis. There is no sharp distinction between these terms; in general, they connote atrophy of the vulvar epithelium with loss of rete pegs, with various other changes: abnormal adherent keratin layer (leukoplakia), superficial ulceration (kraurosis), inflammatory changes in both epithelial and subepithelial tissues (vulvitis). Often severe pruritis is associated, and may precede and be a factor in the development of subsequent carcinomatous change.

The preventive treatment of epidermoid carcinoma includes relief of local irritation from vaginal discharges, glycosuria, etc.; prevention of marked senile changes by the use of estrogens, and simple vulvectomy for the more severe cases of leukoplakia and pruritus. In my opinion, the local application of estrogens in the form of vaginal suppositories or creams for topical application is preferable to systemic medication, unless there are other indications for the latter.

Adenocarcinoma of the vulva has been reported as arising both from sweat glands (hidradenoma carcinomatosum) and from Bartholin's gland. The former usually occurs in the labium majus; occasionally in the sulcus between the labium majus and minus, or on the labium minus (Taussig, op. cit.). According to Novak it is extremely rare, and most hidradenomas are quite benign, even though at first glance the pathologist may think them cancerous. Adenocarcinoma of Bartholin's gland arises just within the introitus, forming a mass palpable through the labia and also through the lateral vaginal wall, resembling in location but not in consistency the common Bartholin's cyst. Strictly speaking, adenocarcinomas in this location probably arise from Bartholin's duct as in the case to be reported, since they occur after the menopause in most cases, and according to most authors the gland atrophies after the menopause. One might draw a parallel here with adenocarcinoma of the breast, which is usually of duct origin.

CASE REPORT

J. S. C. M. C. No. 2857. Admitted November 7, 1941. The patient, a 69-year-old white female, gave a history of slight pinkish vaginal discharge of six weeks duration. She had no other symptoms except nocturia toward morning. She had had one pregnancy 35 years before admission, following which she wore a pessary for prolapse for 15 years. Twenty years before admission a vaginal plastic and amputation of the cervix was performed. Menopause occurred 24 years before admission at age 45.

On examination the following findings were noted: The patient was an obese, well preserved, 69-year-old woman in fairly good general condition. The vaginal introitus was rather tight with some senile atrophy. A firm, non-tender mass was palpable through the left labium majus and also through the left vaginal wall, beginning just within the introitus and extending up almost to the vaginal apex. The cervix was absent and the opening of the uterine canal appeared normal. No ulceration of the vagina was visible through the speculum, but pressure on the vulvar mass caused bleeding from a small depression on the left lateral vaginal wall about 2 cm. within the introitus. A punch forceps could be introduced at least 1 cm. into this depression and granular, friable tissue was obtained. The inguinal nodes were not enlarged. A catheterized urine specimen showed no blood.

* From The Carpenter Memorial Clinic, Memorial Hospital.

A clinical diagnosis of adenocarcinoma of Bartholin's gland was recorded, but the preliminary pathologic report on the biopsy was basal cell carcinoma.

On November 20, 1941, under spinal anesthesia, a wide cautery excision of the tumor mass was performed. The left half of the vulva, including the clitoris, and the entire left vaginal wall to within 1 cm. of the vaginal apex was excised. The dissection was carried deep into the perivaginal and perivesical tissues, until the upper pole of the tumor, which lay above and internal to the arch of the pubis, was reached.

Pathologic report by Dr. H. Russell Fisher on the operative specimen was as follows:

"Gross: Specimen includes 10 cm. of the left vulva, 5 cm. of the left vaginal wall and a large amount of subjacent fatty tissue. The vaginal wall contains an ulcer 1 cm. in diameter. On incision this is found to be a rather deep excavation about 1 cc. in size. It is bounded on all sides by a margin of firm, gray-white tissue so that the whole mass is 4 to 5 cm. in diameter. The outlines are poorly defined, however, and it appears to send out processes into the attached fatty tissues. There is no gross evidence of extension of the tumor tissue beyond the limits of the excision.

"Microscopic: Several sections from the tumor show it to be of epithelial nature, being made up of reduplicated and repeatedly folded, rather broad bands of epithelial cells. These bands are made up of many layers of epithelial cells which, unlike a squamous cell proliferation, tend to be elongated transversely to the line of growth or the imaginary surface, rather than parallel to it. In this way the individual tumor unit resembles a stratified columnar, rather than a stratified squamous, type of epithelium. Mitotic figures are fairly numerous, but the differentiation into the above described type is quite consistent throughout all parts of the tumor. This appears to be a carcinoma of stratified columnar epithelium and as such could easily be interpreted as a carcinoma of the duct of Bartholin's glands, the latter structure having a multi-layered columnar epithelium. It is also to be noted that the general picture or pattern of this tumor coincides with that of a previously reported case of carcinoma of Bartholin's glands.

Diagnosis: Carcinoma of duct of Bartholin's gland."

The patient made an uneventful recovery and on February 9, 1942, 11 weeks after operation, the large operative defect had healed completely and she had no complaint except dyspareunia. She has consistently refused to return for examination since April 24, 1942, but is known to be alive and presumably well on April 24, 1945, three and one-half years after operation.

SUMMARY

Cancer of the vulva is usually an epidermoid carcinoma arising on the basis of preexisting atrophic (senile) change.

A small proportion of vulvar cancer arises in Bartholin's gland.

A case of carcinoma of Bartholin's gland is reported.

REFERENCES

1. Ewing, James: Neoplastic Diseases, 4th Edition, Philadelphia, Saunders, 1940.
2. Taussig, F. J.: Cancer of the Vulva—An Analysis of 155 Cases, Am. J. Obst. & Gynec. 40: 764, 1940.
3. Novak, Emil J.: Gynecological & Obstetrical Pathology, Philadelphia, Saunders, 1940.
4. Boughton, T. G.: Carcinoma of Bartholin's Gland, Am. J. Surg. N. S. 59: 585, March 1943.

ASPIRATION BIOPSY OF THE KIDNEY REGION*

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The diagnosis of the nature of swellings in the kidney region is often difficult and uncertain, and relies on history, physical examination, and x-ray visualization of the calices and pelves with the aid of radio-opaque media. Aspiration biopsy, whereby an attempt is made to obtain material for microscopic examination, is an added diagnostic method which is described and discussed here because so little has been written about it.

Aspiration biopsy for the diagnosis of tumors in various parts of the body was reported by Martin and Ellis in 1930[1], and has since been found useful in many hands. In tumor diagnosis, the procedure has been applied mainly to lesions of superficial structures—skin, breast, bone, and lymph nodes—with the notable exception of Ferguson's[2] work with the prostate.

As to the safety of the method, Stewart [3], referring to aspiration biopsy in general, stated that he had seen no untoward result in

*From the Department of Pathology, Memorial Hospital.

approximately 2,500 cases. Campbell[4] cites Barringer's personal communication that kidney aspiration has not been observed to influence adversely the subsequent clinical course. At this hospital, the kidney region has been punctured 17 times in 14 cases with no apparent harm. Mencher[5] performed perirenal insufflation 22 times in 10 cases without untoward result. McLean and Sugiura[6], investigating the theoretical spread of malignant disease by aspiration, found that moderate or excessive aspiration biopsy procedures performed repeatedly on transplanted carcinoma and sarcoma in rats and mice did not increase the percentage of distant metastasis; nor did it result in implantation of tumor along the route that the needle had traversed.

The aspiration is done with an 18 gauge needle inserted, with aseptic precautions and following local procaine hydrochloride anesthesia, in the angle formed by the twelfth rib and the outer edge of the erector spinae muscles. The sensation of perforating the renal capsule or tumor can often be recognized and the protruding portion of the needle oscillates with respiration. At this point, a syringe is attached and suction is exerted while the needle is advanced into the mass. The aspirating syringe is then detached and the needle is withdrawn. The material from the aspirating needle, is of sufficient amount for paraffin section, is gathered and mounded together on a small piece of filter paper and immediately transferred on the paper to fixing and hardening solution. All the material remains on the paper in a single mass and is easily transferred by means of small forceps through the various solutions. The material is scraped from the paper at the time of embedding.

When an amount of material insufficient for section is obtained, it is smeared between two clean micro-slides as in the common method of smearing urethral pus. The smears are fixed by passing through a flame as in bacteriological technic and are stained the same as tissue sections.

The interpretation of smears requires the pathologist to revise many criteria of malignancy. The smeared, heat-dried cell may assume an appearance very different from the same cell in a mass of tissue after formalin fixation, paraffin embedding, and sectioning. Fortunately enough material was obtained from most of our aspirations to make paraffin sections.

Our series of 14 cases includes 11 in which the aspiration biopsy yielded sufficent material for satisfactory microscopic diagnosis, usually on the first attempt. One patient died without accurate final diagnosis, and the tumor in one patient was located in the lower pole of a ptotic kidney so far below the crest of the ileum that the aspirating needle could not reach it. In only one case was the material insufficient for diagnosis.

REFERENCES

1. Martin, H., and Ellis, E. B.: Ann. Surg. 92: 169, 1930. Surg. Gyn., and Obs. 59: 579, 1934.
2. Ferguson, R. S.: Am. Jour. Surg. 9: 507, 1930, Can. Med. Assoc. Jour. 39: 497, 1933.
3. Stewart, F. W.: Amer. Jour. Path. 9: (supplement), 807, 1933.
4. Campbell, M. F.: J. A. M. A. 109: 1606, 1937.
5. Mencher, W. H.: J. A. M. A. 169: 1338, 1937.
6. McLean, J., and Sugiura, K.: Jour. Lab. and Clin. Med., 22: 1254, 1937.

Case	Sex	Age	Diag. By Aspiration	Correct Diag.	How Confirmed
1	M	3	Embryonal carcinoma	Embryonal carcinoma	Autopsy
2	M	26	Renal carcinoma	Renal carcinoma	Operation
3	M	18	Infected hydronephrosis	Infected hydronephrosis	Operation
4	M	15	Endothelial myeloma	Endothelial myeloma	Autopsy
5	F	33	Cells from renal tubules	?	Not confirmed
6	F	7	Embryonal carcinoma	Embryonal carcinoma	Operation
7	M	11	Embryonal carcinoma	Embryonal carcinoma	Operation
8	F	63	Malignant tumor	Renal carcinoma	Operation
9	M	53	Pus and blood	Hypernephroma	Operation
10	M	50	Carcinoma	Renal carcinoma	Operation
11	M		Insufficient material	Polycystic kidney	Autopsy
12	M	58	Carcinoma	?	Not confirmed
13	F	13 mos.	Embryonal carcinoma	Embryonal carcinoma	Operation
14	F	13 mos.	Embryonal carcinoma	Embryonal carcinoma	Operation

SUMMARY—Aspiration biopsy for the removal of tissue from the kidney region is a simple and apparently safe procedure which gives information of the greatest diagnostic importance.

+ Editorial +

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What Now?

The death of President Roosevelt poses many important questions before the American people—and not least of these, the medical profession—the answers to which will be anxiously awaited. What of the future of medical practice in this country? For some years the Wagner Bill and its congeners had the support of the late President, yet for various reasons it has not yet become law.

At the time of his last inaugural the late President said he expected to steer a course "a little to the left of center" and since the Wagner Bill was far to the left, it is possible he had lost some of his enthusiasm for this measure, especially since he later experienced total defeat in his efforts to have enacted the so-called war manpower bill, ostensibly to provide men for war jobs, but actually designed to regiment labor in peace years so outrageously that even the author of the bill, when its true meaning was made clear, voted against his own bill and, together with a substantial majority of the Senate, killed it.

Now we have a new President, and not only this country but the whole world looks to Washington for pointers as to his program. What are the signs? First, the background of a farm home, and a poor one at that, points to more conservatism than might be expected from a city man, with great wealth. Second, President Truman's first week in office, unprecedentedly trying as it was, was marked by a firmness and a humility, that bodes well. Third, the type of appointments so far made definitely points toward conservatism, at least in financial matters. Fourth, the pending changes in cabinet and departmental key men indicate a course less towards the left. Fifth, his ability to win the approval and support of the Congress in such short order indicates his desire to return to constitutional government, with the legislative branch equal to and coordinate with the executive and judicial.

These items are all to the good and, summed up, point towards the center. If this be the case, American medicine is on safer ground right now than it has been for several years. This Journal looks to the future with equanimity.

Does Labor Want Socialized Medicine?

In the March issue of The Journal we reprinted an editorial from the *Labor Union* of Dayton, Ohio, a weekly publication with a circulation of over 150,000, indicative of the changing attitude that intelligent labor is now taking towards the Wagner Bill that would regiment the practice of medicine in this country.

We reprint below a second editorial from the *Labor Union* that states in clear and forceful language why it is opposed to the Wagner Bill. The *Labor Union* seems to have remembered well those words of caution spoken by Benjamin Franklin: "Those who trade freedom for security generally lose both."

THE LABOR VIEWPOINT

Dangerous legislation.

Some of it is dangerous to one class of individuals and some of its dangerous to another group, but now here comes proposed legislation which is dangerous to all alike.

This is legislation which editorial writers the country over are opposing, and while there are a few good features in the new Wagner Bill—aimed at socializing medicine—few if any of the leading writers can find sufficient good in the Bill to commend it to the public.

"It is doubtful if any legislation has been proposed for Congress that is quite as vicious and deceptive, or that could be more destructive of both human freedom and human self-respect than the new social security bill offered by Senator Robert F. Wagner, of New York City," says an editorial in the Shreveport (La.) Times.

The Times editorial points out that the purpose of this Senate Bill 1161 is its use as a means of enacting into federal law the proposal of President Roosevelt for expansion of that phase of bureaucratic activity of the government.

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The bill would add $12,000,000,000 a year to the taxes of the public, with one-half of it placed directly on the payroll workers.

Under the present system of handling social security that tax money would be available for any government spending, which would mean that in the future years new taxes would have to be imposed to pay the obligations of the social security taxes spent for other purposes.

What this plan proposes for the United States is exactly what Mussolini tried for Italy and what Hitler has been trying to put over in Germany.

What the Congressmen backing this plan are asking the free people of the United States to do is to follow the course that helped put Italy into Mussolini's slavery and then destroyed the people of the nation.

It is a potential final spearhead by which bureaucracy could destroy democracy, freedom and self-respect among American people as a whole.

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What this medical proposal really means is the abandoning of the private practice of medicine and in the end placing medical aid, care and attention under politically selected and approved doctors, druggists, nurses and hospitals.

The right of the citizen to pick his own doctor would be wiped out in the end.

Of course the bill does not in so many words abolish private medical practice as such.

But it makes private medical practice impossible economically, and undesirable from any standpoint.

Under this plan, the American citizen would find that whenever sickness came he would be herded before federal doctors, in federal clinics or federal hospitals, and given mass federal treatment.

Instead of improved public health, such a plan could only in the end destroy it.

Instead of profiting through "government-paid" medical attention, the citizen would find himself a political pauper from the standpoint of health, paying in taxes perhaps $100 for every $25 worth of so-called "service" received.

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What the American public, and particularly the laboring class, should clearly understand is that this plan is not simply a blow aimed at the medical profession, but part of a huge armored force attack which is battering the whole front of freedom, initiative, enterprise, liberty and self-respect for all of the American people.

Fascism, dictatorship, Naziism, Communism or any other "ism" could not come into the United States by one fell swoop—by any overnight governmental action.

Designers of such radical governmental changes move slowly with caution; they build their house stone by stone so that no one step attracts too much attention.

Suddenly it is found that an entire new structure is completed.

It is too late then for Liberty and Freedom to act.

Every step taken, every stone laid, was done in the guise of "helping" some citizen group, of putting money into its pocket, or of making unnecessary the removal of money.

• • •

Actually such programs form one gigantic steal of the citizen's money as well as of his decency, liberty and self-respect.

The bureaucrats insist their political medicine is to build up public health when all it could do would be to build up the politicians and their power.

It is simply one of many similar steps to destroy initiative in one group as similar steps are taken with other groups.

If the medical profession can be destroyed, so can the legal profession, engineering, school teaching, or any other.

There is no problem so needing solution as that of top-grade medical attention for those who cannot pay top prices.

But taxing the workers thousands of dollars to be spent by some medical dictator set up by bureaucrats is no solution.

• • •

At a time when medical science is performing seeming miracles in the discovery and application of new healing agents and operating techniques, and while thousands of American doctors are away in the armed forces serving America and all mankind, along comes this proposal to socialize medicine, as part of a broad scheme to provide "security" for the general public.

The Constitution of the United States gives every man the right to "his day in court," before he can be "counted out" of circulation with his fellow men, although he may be known to be a criminal. But is the medical profession of America being given its "day in court?"

Those members of the medical profession who are risking their own lives on the far-flung battle front of the world in behalf of your fathers, sons or sweethearts—yes, and of thousands and thousands of the womanhood of America, since women are now in every branch of the service—do not have the time nor opportunity to protect themselves from this "stab-in-the-back," which the Wagner bill undoubtedly is.

• • •

The small force of physicians and doctors left in the United States to look after all the millions of war workers and to try to keep the nation in as healthy a condition as possible, are little if any better off than those outside our shores with regards to time to look after their own welfare and the protection of their profession.

Thus it behooves every worker to do all possible to protect his own interests and those of his doctor by fighting this dangerous Wagner Bill, which is Senate Bill 1161. Let your Senator and Representative in Congress know that you want this bill defeated.

AMERICAN CANCER SOCIETY

By Grace S. Young,*
Wilmington, Del.

During the past year the American Society for the Control of Cancer and its auxiliary, the Women's Field Army, changed their titles and, by omitting certain words, increased the scope of their activities. The word "Women's" has been dropped in order to include men. It is now "The Field Army of the American Cancer Society." Some felt that the "Control of Cancer" limited the Society to just the early cases that could be cured by prompt treatment. The Society is still pledged to educating the public to recognize possible cancer symptoms, and to seek immediate treatment. Education is indispensable to the cancer problem, but its salvation lies in research. In between these goals is service to the cancer patient.

Heretofore the Field Army has carried on a roll call in each state, and, with the money raised from membership fees, put on intensive educational programs in cities, towns and villages throughout the country. The workers soon discovered their message of hope had to be bolstered up with financial assistance in many cases. How could a poor sharecropper's wife, for example, heed the advice about that lump in her breast? She has no one to leave with her children, she has no

* Secretary, Delaware State Committee.

money for fare to the city, nor does she know how to find the clinic. The Field Army steps in, finds a woman to care for the family, and arranges for the transportation. In some states where the tumor clinics were too few, or too inaccessible to certain localities, the Field Army under the direction of the Medical Society helped equip clinics at strategic points, sometimes raising all the funds, at others obtaining legislative grants. In a number of large states, they have established Cancer Detection Clinics. Other projects have been hospitalizing indigent patients, endowing beds for cancer cases, employing social workers for follow-up work, making dressings for cancer hospitals, paying for bedside care and drugs, and in some states paying for examinations.

Since Delaware is such a small state, the transportation problem has not been a serious one, but each year the Field Army has provided transportation when necessary and paid the board of special cases that had to remain for treatments over a period of several weeks. Two years ago money was appropriated for hospital expenses over and above Levy Court appropriations in the two lower counties where the Field Army campaign had been particularly successful. Many of the cancer cases from Kent and Sussex counties are sent to Wilmington, and the Levy Courts down state refuse to pay for them and the New Castle Levy Court also objects, since they are not residents of New Castle County. At most, the Levy Court only allows for forty days hospitalization in any one year. Cancer patients often have to remain longer; some go home but have to return later and are no longer eligible for help from the Levy Court. Almost half of the $2,000 appropriated for such needy cases has already been spent since the annual meeting of the Society last January. In addition to the suffering and anxiety caused by advanced cancer is the heavy burden of debt that further breaks family morale.

The workers who come in contact with hopeless cases wonder why medical science does not discover some way of checking the terrible death rate, some way of making cancer a minor instead of a major cause of death. Eric Johnston and other prominent laymen, after conferring with leading specialists, feel that if cancer research were given adequate funds the death rate would be greatly reduced. New technics should be available after the war, and eager young scientists will be released to engage in the work, but funds must be at their command to assure the completion of their experiments. Eric Johnston's faith in this cause is so great that he is acting as national chairman of the enlarged Field Army drive to raise $5,000,000 to carry on the threefold program: education, service, and research.

Delaware has been asked to raise $35,000. In other states there has been an enthusiastic response and mens' committees are doing the major part of the campaigning. There are so many concurrent drives here that so far it has been impossible to find anyone to take active charge of the campaign. Mr. Lammot duPont, a member of the executive board of the Delaware State Committee of the American Cancer Society is the Honorary Chairman. Anyone wishing to contribute to this important crusade against cancer may send a check, drawn to the order of the American Cancer Society, to their local headquarters, c/o Delaware Academy of Medicine, Wilmington.

WAR AGAINST CANCER HOPEFUL
Fortune REPORTS

Eighteen million Americans now alive (one out of eight) are doomed to die of cancer at the present rate, *Fortune* magazine for April points out.

Yet, despite the fact that the cancer death rate has been going up year by year, *Fortune* finds a "changed and encouraged outlook" on the part of scientists. This article, "Cancer: Notes of Hope," follows by eight years *Fortune's* first report on the subject "Cancer: The Great Darkness," for which the magazine was awarded the medal of the American Cancer Society's New York committee in 1937.

Today, says *Fortune*, new research foreshadows "the first original cancer-control principle since a frightened Egyptian doctor had the notion, about three thousand years ago, of burning out the cancer cells.

"The new principle: to prevent or reverse abnormal cell growth by feeding or injection.

"Such a development might entirely elim-

inate surgery and radiation as cancer treatrent, routing cancer as easily as penicillin routs hosts of bacteria and sulfa drugs rout pneumonia. True, such cancer magic (or science) is in the future, a future to be reached, if at all, only after the organized, rational expenditure of millions of dollars and the energies of the best scientific brains the race can muster.

"This month the American Cancer Society launches its first decently ambitious money-raising drive. Eric Johnston heads it, and will try to get from the American public $5,000,000 for education, prevention, and research.

"For polio research, about $500 per polio death becomes available. For cancer, not more than $5. What is needed is emphatically not a cut in polio funds, but an increase in cancer-research funds. But that is not enough.

"Cancer research, like much other medical research, is badly organized. Too many well-intentioned donors make grants with some hopefulness but little plan. Projects struggle to get started, lose support, bear no fruit. Most operations in the war against cancer are brave sorties crippled by lack of rational strategy as well as by supply defects."

But there are signs of improved organization, *Fortune* adds. "Last fall scientists and doctors interested in cancer-genetics research laid down a program of voluntary coordination to be developed under a national committee. When such a committee gets going, any good scientist planning research in cancer genetics, whether on public or private funds, will want to have its encouragement and guidance."

One reason for the rising cancer death rate is that more and more people every year are saved from other diseases by serums, plasma, sulfa, penicillin—only to die of cancer on reaching middle age. On the other hand, early detection is playing its part in the cancer war:

"If treatment is delayed, chances of cancer cure are as low as one in ten. But cures begun early enough may in some types run up to 75 per cent. In the last half century the percentage of recoveries in some types has risen to a level earlier undreamed of. In not too long it should rise even higher, if only as a result of the work of the detection clinics, of which there are now only about ten.

"To these clinics come many persons who think themselves in perfect health but who have the good sense to seek periodic checkup. Among the ostensibly healthy who come to the Strang clinics in New York City 1.5 per cent have cancer.

"Treatment continues to rely, as it has for centuries, on elimination of diseased tissue by removal or destruction"—radiation, with the new one-million-volt precision tube; surgery, backed up by plasma, penicillin and the sulfa drugs. "Yet even after the best treatment some cancers recur."

The current scene in the real cancer drama is laid in the laboratory, where scientists are looking for "cancerigens" (agents which cause cancers, such as certain tars, organic dyes and oils, and arsenic), in the hope that learning how to cause cancer may teach them how to prevent it.

"Scientists have now identified 284 cancerigens—including a whole group of substances related to tar that are extremely potent producers of cancer in rodents. And all in this group share one molecular base. Startingly enough, this molecular structure is also basic to such substances as the female sex hormones and the male sex hormone.

"Some laboratories are investing heavily in hormone research. The notion is that perhaps in the body's manufacture of hormones something may go wrong. Then what are produced may be not proper hormones but others so closely related as to affect the growth of the very tissues affected by the proper hormones."

Another attack is being made on the cancer riddle through the study of enzymes—the substances on which the body's cells depends to transform food material into cell material.

"It has been established that the enzyme content of normal and abnormal cells differs. The aim would be to find a substance that will destroy the particular kind of fuel transport found in the cancer cell, thus starving it out, without materially damaging the kind found in the normal system.

"On the development of such a technique of precision bombing of cancer-cell fuel trans-

port, some chemical researchers, notably Dr. Heron Singher of New York City's Memorial Hospital, are now intensively laboring. He has tried bombing with about 400 different compounds. In test-tube experiments some bombs have shown great power but none has yet worked out in a living cancerous animal.

"Among the reasons is the same one that hitherto has barred administering penicillin by mouth: the complexity of the body process. This year, however, the penicillin problem was solved by Dr. Raymond L. Libby. He developed a new vehicle impervious to the stomach juices, which carries the penicillin to where it is needed. Cancer bombers may someday find such a bomb casing."

While the conquest of cancer still lies ahead, *Fortune* emphasizes that the cancer death rate still might be cut almost in half by "detection, diagnosis, surgery, radiation, and education (see your doctor!)."

MISCELLANEOUS

RECORDS OF IMPAIRED WORKERS MATCH SKILL OF ABLE BODIED

Findings Indicate That Disabled Veterans May Have Efficiency Ratings Comparable To Persons With No Disabilities

Physically impaired workers produce as much as, or possibly a little more than, able bodied workers, and they are dependable, regular in attendance and careful in observance of safety regulations, Verne K. Harvey, M. D., Medical Director, U. S. Civil Service Commission, and E. Parker Luongo, M. D., Assistant Medical Director, U. S. Civil Service Commission, Washington, D. C., report in *The Journal of the American Medical Association* for April 14.

Their findings are based on a comparative study of 2,858 physically impaired workers and 5,523 able bodied workers employed in forty-three establishments of the War and Navy Department, situated in various parts of the country, conducted by the Medical Division of the United States Civil Service Commission. The two physicians point out that the study was made in an attempt to prepare for what they term "the greatest problem of rehabilitation" in the nation's history. They believe that their findings will contribute to the solution of problems affecting many thousands of physically impaired civilians and war veterans seeking employment.

"Men and women in the armed forces," they point out, "are being injured in a maiming war. Advancements in medical science are saving lives, but the number and severity of the injuries being sustained by members of the armed forces are such that this nation will be faced with the greatest problem of rehabilitation in its history. Rehabilitation is not complete unless it results in employment of feasible cases through judicious placement.

'The placement of the disabled veteran in a suitable position involves proper consideration of his mental, vocational and physical capacities as they relate to the requirements of the job. In this connection there still will be a need for educating personnel officials on the employment of the physically impaired, and it can be expected that difficulty of the impaired in securing employment may be again accentuated when present wartime labor shortages are relieved.

"Policies leading to the employment of the physically impaired should not be merely emergency measures; rather, the objective of these policies should be to bring forward a contribution to the solution of the overall problem which will be of even greater significance after the war. Notions concerning job performance of the impaired based on theory or opinion must give way to those based on factual information. The former have been used in the past as a guide by many personnel officials and their medical and safety advisers in recommendations for the employment or nonemployment, of physically impaired individuals. . . ."

Only serious physical defects were considered in selecting impaired workers for the study. Also, the majority of impaired workers coming under this study have been placed in jobs by matching their defects with the physical demands of the job and environmental conditions, so that they may render satisfactory service without being a hazard to themselves or to others. The authors explain that stress was laid on those physical defects most likely to be encountered in the placing of disabled veterans. In selecting able bodied

workers to be matched with the physically impaired, the records of all such workers employed on the same jobs, and under the same supervisors, as the impaired were examined.

In the review of their findings, Dr. Harvey and Dr. Luongo report that the productivity, both in quantity and quality, and the efficiency ratings of the physically impaired were found to compare favorably with those of the able bodied. The best performance with regard to quality and quantity was found among those impaired workers who were craftsmen. Those impaired workers who were employed as laborers accounted for the largest percentage of the class in which the quality of work was worse and the quantity less than that of other sectional workers.

In closing they say, "The commission will continue to stress the need for, and within the limits of its authority aid in the development of adequate health and safety programs for federal employees, so that disabled veterans and other impaired workers will be judiciously placed in positions where they may function proficiently and safely."

New knowledge as to the effective use of chest x-rays and new methods greatly reducing the cost of large numbers of x-ray diagnoses put into our hands far more effective facilities than we have heretofore had for the elimination of tuberculosis. It is now practicable to think in terms of x-raying the entire population of various areas, beginning perhaps with areas in which tuberculosis rates are still high. We can get rather definite estimates as to the number of cases which will be discovered in the various stages of the disease. We can formulate tentative estimates as to the additional number of hospital beds that will be required, and as to the numbers for whom partial or complete rest at home may be adequate. We can also judge as to the frequency with which such x-ray examinations will need to be repeated in any given locality, in order to catch the most recent infection.—Homer Folks, *Amer. Jour. P. H.*, Feb., 1944.

BOOK REVIEWS

Medical Gynecology. By James C. Janney, M. D., Assistant Professor of Gynecology, Boston University School of Medicine. Pp. 389, with 97 illustrations. Cloth. Price, $5.00. Philadelphia: W. B. Saunders Company, 1945.

Janney's book is limited to office gynecology and approaches the subject from the standpoint of the patient's complaints. While a comparatively small text, it is unexpectedly complete. To this reviewer its most appealing virtue is its practicality, which is evident throughout. The chapters on socio-medical problems in gynecology, including marital maladjustments, are excellent.

We believe this book will prove to be exceedingly popular, as it deserves to be.

Military Medical Manuals—A Manual of Tropical Medicine. Prepared under the auspices of the Division of Medical Sciences of the National Research Council. Pp. 727, with 284 illustrations. Cloth. Price, $6.00. Philadelphia: W. B. Saunders Company, 1945.

This Manual, one of a series, represents the experience of three officers of the Army Medical School, with the collaboration of seven others, including Col. Richard P. Strong, dean of tropical medicine in America. It fills a long felt need of a concise treatise in this field. Naturally, it includes many subjects that are not wholly tropical. This text is definitely authoritative. The illustrations are well-chosen and well done: the six in colors, on malaria, are excellent. The index is remarkable.

Due to the global nature of this war, this volume should be on the desk of every physician who treats personnel returned from most of the theatres of operations.

Peripheral Nerve Injuries. By Webb Haymaker, Capt., M. C., A. U. S., Neuropathologist, The Army Institute of Pathology, Washington, D. C., (on leave of absence from the University of California; and Barnes Woodhall, Maj. M. C., A. U. S., Chief, Neurosurgical Section, Walter Reed General Hospital, Washington, D. C. (on leave of absence from Duke University). Pp. 227, with 225 illustrations. Cloth. Price, $4.50. Philadelphia: W. B. Saunders Company, 1945.

This is a rare book. First, the text is boiled down to the barest essentials; second, the illustrations are exceptionally informative. For the last two decades most of us have been looking for the answers and have not found all of them in any one text book. Now comes this haymaker (with apologies to the senior author) from the unequalled material found in the Army Institute of Pathology, which not only epitomizes all that the other texts have established but also adds new information gleaned from the vast material furnished by the present war. The neuro-surgeons perhaps do not need to have this book; the general and the orthopedic surgeons *must* have it.

Dietotherapy—Clinical Application of Modern Nutrition. Edited by Michael G. Wohl, M. D., Associate Professor of Medicine, Temple University School of Medicine. With a foreword by Russell M. Wilder, M. D., Ph. D., Professor of Medicine, Mayo Foundation. Pp. 1029, with 93 illustrations. Cloth. Price, $10.00. Philadelphia: W. B. Saunders Company, 1945.

Wohl, along with 56 collaborators, all of them eminent in their respective fields, has not produced just another text book on dieteties: this is a composite text that covers every aspect of nutrition, and covers them well. The advice given is eminently practical, and no other one-volume book that we know of covers as many aspects of the problem. Dr. Wilder's Foreword is thought-provoking.

This is an excellent work, and we heartily recommend it.

Trauma in Internal Diseases: With Consideration of Experimental Pathology and Medicological Aspects. By Rudolf A. Stern, M. D., Assistant Attending Physician, City Hospital, New York. Pp. 575. Cloth. Price, $6.75. New York: Grune & Stratton, 1945.

The contents of this book is indicated by its title. We were especially interested in the sections on traumatic appendicitis and peritonitis, with which we largely agree. We were disappointed to find no discussion of traumatic inguinal hernia, a debatable question in most judicial jurisdictions, especially workmen's compensation boards.

However, since this book represents the first substantial study in America on trauma in internal diseases we believe it will be of interest and value to attorneys and those physicians who may be called upon to testify in court about such matters.

Constitution and Disease: Applied Constitutional Pathology. By Julius Bauer, M. D., Professor of Clinical Medicine, College of Medical Evangelists, Second Edition. Pp. 247. Cloth. Price, $4.00. New York: Grune & Stratton, 1945.

This little volume by the former Professor of Medicine at the University of Vienna deals with the constitutional or genetic standpoint of disease, with stress on the endocrinological factors. Too many doctors of today overstudy this disease that has the patient and understudy the patient that has the disease. The fact that Bauer's book, even in war times, was popular enough to call for a second edition within three years shows the need for such an unusual treatise. This book is not easy reading—it demands concentration and thought, and because it does, it will repay the readers. The book is intended "to familiarize the reader with the principles of 'constitutional thinking' at the patient's bedside," and we endorse it for just that.

My Second Life. By Thomas Hall Shastid, M. D. Pp. 1174, illustrated. Cloth. Price, $10.00. Ann Arbor, Michigan: George Wahr, 1944.

This is the autobiography of an ophthalmologist, aged 79 years, who has seen much of the history of the middle west and of the nation. His family history may not interest the present generation too much, but his personal knowledge of or acquaintance with many of Americas' notables of the preceding century makes a most interesting tale. The illustrations include many rare items—homes, statues, portraits, and documents. The author is to be congratulated upon his sincere, though rather detailed, opus.

Medicine Men and Men of Medicine. By Charles M. Bayer. Pp. 48. Paper. Price, 10 cents. New York: Medical Society of the State of New York, 1945.

This little brochure was written to be of permanent educational value in tracing the growth and survival of quackery side by side with the development of scientific medicine. It succeeds in its purpose. Interesting and informative, its major theme is chiropractic, which it exposes unmercifully.